North Carolina Department of Health and Human Services

NC Medicaid

Cystic Fibrosis Medications PA Request Form

(**Kalydeco, Orkambi, Symdeko, and Trikafta**)

Beneficiary Information

1. Beneficiary Last Name:_____2. First Name:_____

3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____5. Beneficiary Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Information Name:_____Phone #:_____Ext:_____

Drug Information

8. Med requested: _____ 9a. Strength: _____9b. Quantity per 30 days_____

9c. Requested Duration (circle # days): 30 60 90 120 180

Requests for KALYDECO (answer questions 10- 14)

10. Does the beneficiary have a diagnosis of Cystic Fibrosis? Yes___No___

11. Is the beneficiary age 6 months or greater? Yes___No___

12. Does the beneficiary have a documented mutation in the CFTR gene that is responsive to ivacaftor? Yes___ No____Please list._____

13. Is the total daily dose 300mg/day or less? Yes___No___

14. Have a baseline ALT and AST been assessed prior to beginning therapy? Yes___No__

Requests for ORKAMBI (answer questions 15- 19)

15. Does the beneficiary have a diagnosis of Cystic Fibrosis? Yes___No___

16. Is the beneficiary age 2 years or greater? Yes___No___

17. Is there documentation that indicates the beneficiary is homozygous for the *F508del* mutation in the *CFTR* gene? Yes___No___

18. Is the total daily dose lumacaftor 400 mg/ivacaftor 250 mg or less? Yes___No__

19. Have a baseline ALT and AST been assessed prior to beginning therapy? Yes___No__

Requests for SYMDEKO (answer questions 20- 24)

20. Does the beneficiary have a diagnosis of Cystic Fibrosis? Yes___No___

21. Is the beneficiary age 6 years or greater? Yes___No___

22. Is there documentation that indicates the beneficiary is documented as homozygous for the F508del mutation in the CFTR gene or does the beneficiary have one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor? Yes___No___

23. Is the daily dose one tablet in the morning and one tablet in the evening? Yes___No__

24. Have a baseline ALT and AST been assessed prior to beginning therapy? Yes___No__

Requests for TRIKAFTA (answer questions 25- 30)

25. Does the beneficiary have a diagnosis of Cystic Fibrosis? Yes___No___

26. Is the beneficiary age 12 years or greater? Yes___No___

27. Is there documentation that indicates the beneficiary has at least one copy of the F508del mutation in the CFTR gene? Yes___No___

28. Is the total daily dose two tablets (elexacaftor 100 mg, tezacaftor 50 mg and ivacaftor 75 mg) in the morning and one tablet (ivacaftor 150 mg) in the evening or less? Yes___No___

29. Have a baseline ALT, AST, and bilirubin been assessed prior to beginning therapy? Yes___No__

30. If the beneficiary is less than 18 years of age, has a baseline ophthalmic examination been performed? Yes__No_

Signature of Prescriber:_____Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

This form can be uploaded into the secure NCTracks Provider Portal, faxed, or mailed to NCTracks. Fax all forms and lab work to NCTracks at: (855) 710-1969. Pharmacy PA Call Center: (866) 246-8505.